BRIAN TELIHO, MD

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF TENNESSEE

AT CHATTANOOGA

ALEX HIXON,

Plaintiff,

vs.

TENNESSEE VALLEY AUTHORITY BOARD OF DIRECTORS,

Defendants.

Case No. 1:19-cv-00120-PLR-SKL

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Volume I

REMOTE DEPOSITION OF BRIAN TELIHO, MD

Kahului, Hawaii

Wednesday, June 10, 2020

Reported by:
ELIZABETH BORRELLI, CSR No. 7844, CCRR, CLR
JOB NO. 180373

BRIAN TELIHO, MD

Remote deposition of BRIAN TELIHO, MD, Volume I, taken on behalf of the Defendant, at Kahului, Hawaii, commencing at 8:05 a.m., Wednesday, June 10, 2020, before Elizabeth Borrelli, a Certified Shorthand Reporter in the State of California, License No. 7844.

* * *

APPEARANCES OF COUNSEL:

For the Plaintiff:

MIKEL & HAMILL
BY: DOUGLAS HAMILL, ESQ.
620 Lindsay Street
Chattanooga, TN 37403

For the Defendant:

OFFICE OF THE GENERAL COUNSEL
TENNESSEE VALLEY AUTHORITY
BY: MARK MOHR, ESQ.
BY: MICHAEL BERNIER, ESQ.
400 West Summit Hill Drive
Knoxville, TN 37902

BRIAN TELIHO, MD

I N D E X

EXHIBITS

BRIAN TELIHO, MD

INFORMATION REQUESTED

(None)

UNANSWERED QUESTIONS

(None)

BRIAN TELIHO, MD

KAHULUI, HAWAII; WEDNESDAY, JUNE 10, 2020

8:05 A.M.

BRIAN TELIHO, MD,

having been duly administered

an oath in accordance with CCP 2094,

was examined and testified as follows:

MR. MOHR: Good morning or good afternoon, depending on where everyone is here. My name is Mark Mohr. I'm an attorney with TVA. My colleague Mark Bernier is also joining us. And then I have Doug Hamill with us as well, plaintiff's attorney.

EXAMINATION

BY MR. MOHR:

Q. Before we begin, I just want to go over some of the basics here.

Have you given any depositions before?

A. Yes.

Q. Okay. So some of this may be familiar, but I'll -- I'll over it one more time.

Especially with this being a remote deposition, please let me know if you have any technical difficulties just so we can address those right away.

incident in around -- around January 2014?

A. Yes.

Q. Okay. Prior to that, had you ever spoken to Mr. Hixon about the possibility of taking MARINOL?

A. Not to my knowledge. I don't recall that, no.

Q. What was your reaction to learning that he was taking MARINOL?

A. I think, in my progress note at the time, I expressed that it was an odd decision. MARINOL is something that we typically use for -- at least at that time, it was primarily used for appetite stimulation, some pain management folks who were struggling with cancer. In more recent years, it has been used more as an anxiolytic, or something to help with anxiety and insomnia, but it wasn't part of my regular repertoire of medications that I would usually prescribe for someone with those symptoms.

Q. And when you say "those symptoms," specifically what symptoms are you referring to?

A. As I recollect, I think Alex was prescribed the MARINOL to help with his insomnia and anxiety.

Q. So, to be clear, at that time, in your experience, was it common for a patient to take MARINOL for depression, anxiety, or insomnia?

A. Depression, no. I have -- you know, I -- I -- I am aware of patients who would take that periodically for off-label uses. That's just not something that I would do frequently personally, but there are other physicians who do support that claim, and, as I'm sure you're aware now, it's more commonplace to recommend cannabis or cannabinoid substances to help with anxiety and insomnia.

Q. Have you ever prescribed it yourself?

A. No.

Q. And why have you never -- never prescribed it?

A. Much of my training involved -- my early training, I worked with a lot of patients with psychosis or schizophrenia, and cannabis, in and of itself, is a hallucinogen. So I would periodically see patients whose psychosis would worsen on cannabis. I would see patients whose anxiety improved, but when it came to mood disorders, I never thought it was a great idea to introduce a hallucinogen, as such, for the fear of potentially

worsening thought patterns or inciting psychosis.

Q. What -- what other affects does MARINOL have besides being a hallucinogenic?

A. Well, the -- the purposes it was originally developed, as I said earlier, were to help stimulate appetite, help with some pain management. Particularly, there's studies there with cancer patients to whom it was prescribed, predominately. But I can see it helping with insomnia; I can see it helping with anxiety, but those weren't -- those weren't the primary reasons it was developed.

Q. Are there any side effects common with MARINOL?

A. I would see fatigue as a potential side effect.

Q. Does it -- does it commonly have any adverse interactions with think other medications, that you're aware of?

A. Not that I'm aware of, no.

Q. Are there any, maybe, classes of individual -- go ahead.

A. I was just going to say, you know, as a potential side effect, the fatigue, if -- if one is

during that visit?

A. My idea of Mr. Hixon, really, from 2013 on has -- is such that he's struggled with chronic depression. There are periods of time when he appeared stable, meaning I wasn't worried about him killing himself, but I don't know that I've seen Alex, since 2012, feel good. Pretty much every time we would meet, he would share struggles, problems with mood, ongoing problems with energy, sleep, motivation, you know, the typical symptoms of depression one has. There were periods when he was more down and I was more concerned about him, but I've really not known Mr. Hixon to be doing well, yeah.

Q. Okay. And how would that affect his day-to-day life when those -- those symptoms where he was not doing well?

A. I would expect Mr. Hixon would struggle with his mood. He -- he might struggle more with his ability to focus, his ability to motivate himself to complete tasks. He -- it may -- may negatively affect interpersonal relationships. These are all things depression can do.

Q. When was your first meeting with

Mr. Hixon?

A. It would have been when he first came to see me to ask about potential TMS therapy.

Q. And what were your initial impressions of his condition then?

A. That he struggled with major depressive disorder.

Q. How did you go about evaluating him during that initial session?

A. Standard psychiatric evaluation, an interview. It probably lasted anywhere from 30 to 60 minutes.

Q. What topics do you cover in a standard interview?

A. Patient's history as well as current symptoms and ruling out other conditions as well. So if somebody presents with depression, I want to make sure there aren't any obvious could be founding conditions that could muddy the water or cloud the diagnosis. And getting a history of previous treatments or their history of either suicide attempts or psychiatric hospitalizations or family history is helpful, get a sense of what their life is like day-to-day.

Q. And were -- were you -- when you're -- when you're talking about prior conditions, will you limit yourself to mental health conditions or will you ask about other conditions, physical conditions as well?

A. I'll usually ask about general physical health as a way to see if there are physical health conditions that can predispose to depression. As an example, diabetes, cancer, certain types of physical health conditions that are chronic, dermatologic conditions, one will frequently have co-morbidities with depression.

Q. I want to direct your attention again to that Exhibit 1, the first page of your notes. You mention conducting a motor examination.

What is that?

A. Motor -- yeah, so motor exam is normal. That really just refers to my observations of his movement. Basically, from a psychiatric perspective, how someone moves, how someone carries themselves while sitting for an hour is telling. It's body -- you know, it's body language. Is there gait normal when they walk in and out of the room? Are they shuffling? You know, are they rushed? Do

they need to pace? You can image someone who is quite anxious being unable to sit still for an hour. They need to wring their hands, fidget, get up, walk around, sit back down. Other people come in and they could be so depressed they're almost like a bump on a log. They don't move at all. So that's a motor exam from a psychiatric perspective. I'm not doing a neurological exam, no.

Q. Okay. Also, in your notes, you mention asking about social relationships.

Is that something you'll typically inquire about when assessing an individual?

A. Yes.

Q. And why do you do that?

A. Most people in this world don't live in isolation. We have other people in our lives that give it meaning. There's some people who struggle to maintain adequate interpersonal social relationships that are necessary for good mental health. The more we live in isolation, the more likely we become the Unabomber, so it's important to have other people in our lives. That's why I ask.

Q. Are you familiar with the MMPI test?

A. Yes.

Q. What is that test?

A. The MMPI stands for the Minnesota Multiphasic Personality Inventory and it is a psychological tool to help address diagnostic questions. It can also sometimes help delineate or flesh out different aspects of one's personality as well as primary conditions, such as depression or ADD or anxiety, if you will.

Q. And is it common practice for a doctor treating a patient with depression to administer such a test?

A. A psychiatrist, no. That would be something that a psychologist would typically employ. But sometimes we work together in unison to -- you know, if there's a case where symptoms are not adding up or they don't mesh well, we will frequently order an MMPI through a psychologist to try to help with diagnostic clarification.

Q. So, to be clear, have you ever ordered one?

A. Over the -- my years of practice, yes, but I -- I don't recall ever doing that with Mr. Hixon.

Q. In your experience, how reliable is the MMPI?

Q. Do you recall ever discussing his work at TVA with him?

A. Not in any detail, no. Most of what we would talk about were struggles with interpersonal relationships or family life or aches and pains, physical health issues he was having and how they affected his mental health. I don't recall many conversations about his work.

Q. Do you recall any discussions with interpersonal relationship struggles with colleagues of his at work?

A. No.

Q. In January 2014, do you know who from TVA contacted you?

A. I want to say it was a psychologist or -- or someone with -- with that credential, but I can't be certain.

Q. Hold on one second.

A. Certainly.

Q. I apologize. I'm still relatively new to this program.

A. Okay.

Q. I'll pull up what I will mark as Exhibit 3.

of most people with depression, that they'll have periods of relative calm and then, you know, mood will decline again. Much like the tides come in and out daily, this happens with our moods, so yes.

Q. And what triggers those changes?

A. That's the Nobel Prize, right? I don't know. It could be some -- you know, it could be some precipitating event, the end of a relationship, the death of a loved one. I mean, that -- sometimes there are obvious triggers, but, frequently, there are no precipitating events and someone's mood just declines gradually over a number of days or weeks and -- and they're doing much worse.

Q. Does depression ever manifest itself physically?

A. Yes.

Q. What are some of the common ways it will manifest itself physically?

A. There was a pharmaceutical company that had an ad years ago that said "depression hurts." And, in that regard, it -- it's -- it's sometimes easy to extrapolate. Many people with depression physically ache and are more prone to report pain as feeling worse than someone who isn't depressed. If

I -- you know, if you're depressed and you stub your toe on the end table, it's going to hurt you and bother you all day. If you just win the lottery and you're doing really well in life and you stub your toe, you may not feel it at all. So how we -- how we feel emotionally can certainly guide or determine how physical pain is experienced.

Q. Okay. We're almost through here. Just a couple of -- couple of additional questions.

A. Okay.

Q. Have you ever been convicted of anything?

A. No.

Q. Any civil judgments against you?

A. No.

Q. Any pending lawsuits against you?

A. No.

Q. Apart from depositions, have you testified before?

A. No.

Q. Okay. Have --

A. Let me -- let me -- let me clarify. As medical director for Grady Memorial Hospital in Atlanta, the psychiatric department, I would oftentimes represent the hospital in cases where we

BRIAN TELIHO, MD

I, BRIAN TELIHO, MD, do hereby declare under penalty of perjury that I have read the foregoing transcript; that I have made any corrections as appear noted, in ink, initialed by me, or attached hereto; that my testimony as contained herein, as corrected, is true and correct.

Executed this _____ day of

_____, 20____, at

_____, _____.

(City) (State)

_____

BRIAN TELIHO, MD
Volume I

BRIAN TELIHO, MD

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

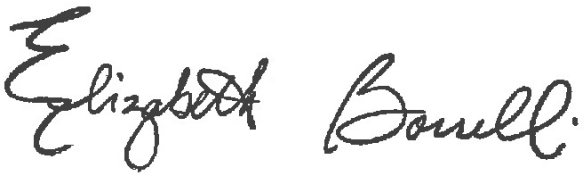
I, Elizabeth Borrelli, Certified Shorthand Reporter, Certificate No. 7844, for the State of California, hereby certify:

I am the deposition officer that stenographically recorded the testimony in the foregoing deposition;

Prior to being examined the deponent was by me first duly sworn;

The foregoing transcript is a true record of the testimony given.

DATED: JUNE 22, 2020



Elizabeth Borrelli, CSR No. 7844